Department of Mental Health & Substance Abuse Services

LICENSURE APPLICATION ADDENDUM: FACT SHEET FORM

INSTRUCTIONS: This form is an addendum to the application for license and is to be used to describe the facility/service to be operated at a given site/location. A separate Fact Sheet is required for each location. This completed form must accompany an application for initial license to operate a newly established facility/service. Current licensees must use this form when applying for a license to operate a newly established site/location, to add a new category to an existing license, to relocate a currently licensed facility/service to another location, or a major renovation, expansion, or change in use or occupancy of a currently licensed facility.

1. Name of Applicant (if individual) or Company/Licensee Name if registered with TN Secretary of State **DATE:**

_____ _____

2. PURPOSE OF FACT SHEET: Identify the reason for the completion of this fact sheet: (Check one)

a. ☐ Application for license by new applicant to operate a newly established facility/service. (An Initial Application must accompany this Fact Sheet.)

b. ☐ Application by current licensee to establish a new site/location.

c. ☐ Application by current licensee to relocate a currently licensed facility/service to another location. (Licenses are not transferrable.)

d. ☐ Application by current licensee to add new category/service to currently licensed site/location.

e. ☐ Application by a current licensee for approval of a major renovation, expansion, or change in use or occupancy of a currently licensed facility. (A new License may be required for certain renovations and expansions.)

3. NAME AND LOCATION OF FACILITY/SERVICE: Identify this facility/service as it is to be named by the applicant, known to the public, and listed on the license:

Facility/Service Name: _____

Street Address: _____

City: _____ **Zip Code:** _____ **County:** _____

Facility/Service Phone Number: _____ **Fax Number:** _____

Is the location of the facility/service inside of city limits? ❑YES ❑NO

4. DISTINCT CATEGORY(IES): Identify the distinct category(ies) of this facility/service as defined in the licensure rules: (If site is currently licensed, only mark category(ies) that are being added to current site.)

Mental Health
- ❑ Adult Day Treatment Services
- ❑ Adult Residential Treatment Program (# of beds _____)
- ❑ Adult Supportive Residential (# of beds _____)
- ❑ Crisis Stabilization Unit (# of beds _____)
- ❑ Hospital (# of beds _____)
- ❑ Intensive Day Treatment for Children & Adolescents
- ❑ Outpatient
- ❑ Partial Hospitalization Programs
- ❑ Psychosocial Rehabilitation Program
- ❑ Residential Treatment for Children & Youth (# of beds _____)
- ❑ Supportive Living Facility (# of beds _____)
- ❑ Therapeutic Nursery

Alcohol and Drug Abuse
- ❑ DUI School
- ❑ Halfway House Treatment (# of beds _____)
- ❑ Non-Residential Office-Based Opiate Treatment (OBOT)
- ❑ Non-Residential Office-Based Opiate Treatment (OBOT Plus)
- ❑ Non-Residential Opioid Treatment
- ❑ Non-Residential Rehab Treatment
- ❑ Outpatient Detoxification Treatment
- ❑ Residential Detoxification Treatment (# of beds _____)
- ❑ Residential Rehabilitation Treatment(# of beds _____)
- ❑ Residential Treatment for Children and Youth (# of beds _____)

Non-Medical Home Health
- ❑ Personal Support Services Agency

5. SITE MANAGER/DIRECTOR: Identify the person who is charged with the overall daily management of this facility/service:

Name: _____ **Title:** _____

Email Address: _____ **Phone Number:** _____

Has this person ever been convicted of or currently under any charges of a felony offense under the law? ❑YES ❑NO
If yes, attach an explanation of the situation, date, type and place of the charge, court action taken, or current disposition

NOTE: ITEMS NUMBERED (7) THROUGH (22) DO NOT APPLY TO PERSONAL SUPPORT SERVICE AGENCIES, DUI SCHOOLS, OR OBOTS.

6. **NUMBER OF BUILDINGS:** Identify the number of buildings on the site of this facility which are to be used for service recipient residences or other service recipient programs: ____. If more than one (1) building is to be used at this address, then list each building by its name or location on the premises, the number of service recipients to reside or to be served in each building, and give the primary use of each building.

   Name/Location of Building _____
   Primary Use of Building _____
   Number of service recipient(s) to reside or to be served in this building _____
   Are any of the service recipient(s) six years of age or younger? ❑ YES ❑ NO

   Name/Location of Building _____
   Primary Use of Building _____
   Number of service recipient(s) to reside or to be served in this building _____
   Are any of the service recipient(s) six years of age or younger? ❑ YES ❑ NO

   Name/Location of Building _____
   Primary Use of Building _____
   Number of service recipient(s) to reside or to be served in this building _____
   Are any of the service recipient(s) six years of age or younger? ❑ YES ❑ NO

7. **SHARED OCCUPANCY:** Are there other activities or occupants in this building(s) which are not under the control of the licensee/applicant?
   ❑YES ❑ NO If yes, describe:

   _____
   _____

8. **HOURS OF OPERATION:** Indicate the normal days and hours of facility's operation. _____

9. **MOBILE, NON-AMBULATORY SERVICE RECIPIENTS:** Are mobile, non-ambulatory persons (persons using wheelchairs, walkers, etc.) to be served in this facility? ❑YES ❑NO
   If yes, are these persons capable of transferring unassisted from a bed or other fixed position into the wheelchair or other mobility device and traversing a predefined means of egress from the facility? ❑YES ❑NO

10. **SERVICE RECIPIENT SELF-PRESERVATION:** Are all of the persons to be served in this facility capable of self-preservation by responding to an emergency signal, including prompting by voice, and following a pre-taught evacuation procedure from the facility? ❑ YES ❑ NO
    Are any individuals to be served in this facility deaf? ❑ YES ❑ NO Are any individuals to be served in this facility blind? ❑ YES ❑ NO

11. **SECURITY MEASURES:** Are security measures, such as exit doors or windows locked against client egress, restraints, or seclusion, which are beyond the client's control to be used in this facility? ❑ YES ❑ NO If yes, explain below:

    _____
    _____

12. **VOCATIONAL ACTIVITIES:** Are vocational activities of an industrial or productive nature such as contract work, assembling, packaging, woodworking, metalworking, painting, stripping, etc., to be conducted in this facility? ❑YES ❑NO

13. **FOOD SERVICE:** Are food service, food preparation, and/or meals to be provided by this facility to the service recipients of the facility on a regular basis?
    ❑ YES ❑ NO

14. **TRANSPORTATION:** Will persons served by this facility/service be transported by facility/service staff: ❑YES ❑NO

15. **BATHROOM ACCOMMODATIONS:** Number of separate bathtubs or shower stalls:_____
    Number of toilets: _____Number of urinals: _____ Number of sinks or hand lavatories in bathrooms:_____

16. **WATER/SEWER:** Is drinking water furnished by a well/spring located on the property? ❑YES ❑NO
    Is sewage handled by a septic tank located on the property? ❑YES ❑NO

17. **BUILDING CONSTRUCTION:** This facility is to be located in: (check one)
    ❑ A building to be constructed or under construction **OR** ❑ An existing building to be adapted for the facility's use.
    A. Number of stories or floors: _____ Basement: ❑YES ❑NO
    B. Indicate the building's type of construction: (check one) ❑Wood frame with wood, shingle, or metal siding ❑Wood frame with brick veneer
       ❑ Reinforced concrete with steel members ❑ Masonry block, with wood frame members ❑Masonry Block, no wood frame members
       ❑ Other, describe: _____

18. **SQUARE FOOTAGE:** Total occupiable space of facility in square feet:_____

19. OWNERSHIP OF PREMISES: Identify the ownership of the buildings, premises, or real property where this facility is to be located: (Check One.)

- ❑ Owned by the applicant free of mortgage.
- ❑ Owned by the State of Tennessee
- ❑ Mortgage Lender: Name:_____
- ❑ Leased from: Address:_____
- ❑ Donated by City/State/Zip Code:_____

NOTE: ITEMS 20 THROUGH 22 ARE TO BE ANSWERED ONLY FOR RESIDENTIAL FACILITIES.

20. RESIDENTIAL SERVICE RECIPIENTS. Number of services recipients who are to reside in facility: _____

21. LIVE-IN STAFF. Number of staff members, proprietors, or family members of the staff or proprietor who reside or have sleeping arrangements in this facility? _____

22. NUMBER OF ROOMS. Service recipient bedrooms: _____ Staff or other bedrooms: _____ Bathrooms: _____

Living Rooms: _____ Dens: _____ Dining Rooms: _____ Kitchens: _____

23. OTHER. Use this space to provide any additional information or to explain any of the above items:

_____

_____

_____

_____

_____

AUTHENTICATION OF INFORMATION. The information contained in this fact sheet is an addendum to, or a part of the application for a license. The person signing below must be the individual applicant in the case of a proprietorship or partnership; or the chairperson or equivalent officer of the governing body in the case of a corporation or other association making application; or in the case of a governmental agency or state university, the person charged by the appointing authority with responsibility for the operation of the facility/service.

I HEREBY DECLARE THE INFORMATION CONTAINED IN THIS LICENSURE APPLICATION ADDENDUM TO BE TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I FURTHER DECLARE MY AUTHORITY AND RESPONSIBILITY TO CERTIFY THIS INFORMATION IN MAKING APPLICATION FOR LICENSE TO CONDUCT THE FACILITY DESCRIBED HEREIN. I AGREE TO COMPLY WITH THE RULES PROMULGATED FOR THE OPERATION OF THIS FACILITY/SERVICE UNDER TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4.

SIGNATURE OF APPLICANT OR AUTHORIZED AGENT	TITLE
_____	_____
TYPE OR PRINT NAME OF AUTHORIZED AGENT	DATE
_____	_____